

JAN 28 2020



**Monroe Energy, LLC**  
**4101 Post Road**  
**Trainer, PA 19061**  
**(610) 364-8000**

January 27, 2020

**Via FedEx 7773 9832 3739**

Mr. James Rebarchak  
Commonwealth of Pennsylvania  
Department of Environmental Protection  
Southeast Regional Office  
2 East Main Street  
Norristown, PA 19401

**Re: Monroe Energy, LLC – Trainer Refinery**  
**40 CFR 63, Subpart DDDDD: Boiler MACT Annual Compliance Report**  
**Reporting Period: January 1, 2019 – December 31, 2019**

Dear Mr. Rebarchak:

In accordance with 40 CFR Part 60 Subpart DDDDD, Monroe Energy, LLC's Trainer Refinery hereby submits this annual compliance report (per §63.7550(b)(1)) for the period beginning January 1, 2019–December 31, 2019. No deviations from the work practice requirements occurred during the reporting period.

Should you have any questions or comments regarding this report, please contact Leia Heritage, Air Permitting Compliance Engineer at (610) 364-8528 or myself at (610) 364-8399.

Sincerely,

Matthew Torell, P.E.  
Environmental Leader

Attachment 1 - Responsible Official Certification  
Attachment 2 - Boiler MACT Annual Compliance Report

**Via FedEx 7773 9857 5867**  
U.S. EPA, Region III  
Director, Air Protection Division  
Mail Code 3AP20  
1650 Arch Street  
Philadelphia, Pa 19103-2029

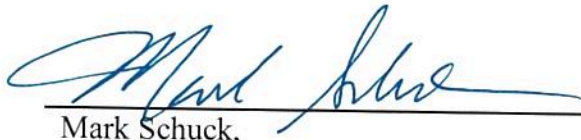
Attachment 1



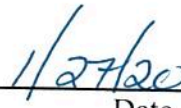
**Monroe Energy, LLC**  
**4101 Post Road**  
**Trainer, PA 19061**  
**(610) 364-8000**

**Responsible Official Certification**

Based upon information and belief formed after a reasonable inquiry, I, as a responsible official of the above-mentioned facility, certify the information contained in this report is accurate and true to the best of my knowledge.



Mark Schuck,  
VP, Refinery Operations



Date

Monroe Energy, LLC – Trainer Refinery  
40 CFR 63, Subpart DDDDD: Boiler MACT Annual Compliance Report  
Reporting Period: January 1, 2019 – December 31, 2019

## Attachment 2

**Boiler MACT Annual Compliance Report**

**Company Name:** Monroe Energy LLC  
**Facility Name:** Trainer Refinery  
**Address:** 4101 Post Road  
 Trainer, PA 19061  
**Reporting Period:** January 1, 2019 - December 31, 2019

Title V Source ID	Source ID Permit Description	Title V Listed Duty (MMBtu /hr)	Date of Most Recent Tune Up <sup>1</sup>	Date of Most Recent Burner Inspection or N/A for delay until unit shutdown
034*	Boiler 9	349.6	8/14/2018	5/15/2019
035*	Boiler 10	349.6	8/14/2018	6/5/2019
053*	Boiler 14	346.9	8/14/2018	7/9/2018
733	FCCU Feed Heater	63	5/7/2019	N/A <sup>2</sup>
735	Kerosene/HCN HTU Heater	23	6/11/2019	6/5/2017
736	Diesel HTU Heater	39	6/20/2019	N/A <sup>2</sup>
737*	Naphtha HDS Heater	76	7/10/2019	9/24/2018
738*	Platformer Feed Heater	913	7/9/2019	10/17/2018
739	Isocracker 1st Stage Heater	50	8/5/2019	2/24/2018
740	Isocracker Splitter RBLR	76	8/5/2019	2/24/2018
741	D2/VGO Hydrotreater Feed Heater	56	6/20/2019	11/15/2016
742	VCD 541 Vac Heater	56	6/11/2019	N/A <sup>2</sup>
743	VCD 542 Vac Heater	72	6/11/2019	N/A <sup>2</sup>
744	ACD 543 Crude Heater	514 <sup>3</sup>	6/12/2019	10/15/2019
745*	ACD 544 Crude Heater	514 <sup>3</sup>	6/12/2019	4/5/2017
746	VCD 544 Vac Heater	229 <sup>3</sup>	6/12/2019	N/A <sup>2</sup>
747 <sup>4</sup>	Effluent Heater H-124-01	71.76	7/10/2019	N/A <sup>2</sup>
748 <sup>4</sup>	Stripper Reboiler Heater H-124-02	44.2	7/10/2019	N/A <sup>2</sup>

<sup>1</sup> All sources subject to Boiler MACT burn only Gas 1 fuels (i.e. refinery fuel gas). The only requirement is a tune up. Also, none of these sources are limited-use boilers or process heaters.

<sup>2</sup> Burner inspection was delayed until the next unit shutdown per 40 CFR 63.7540(a)(10)(i).

<sup>3</sup> No heat input capacity listed for this heater, units are in MCF/HR.

<sup>4</sup> This source is currently permitted in plan Approval 23-0003 AC

\*These sources have oxygen trim systems and only require tune ups (per §63.7550) every five years.

## Health History

Name: \_\_\_\_\_ Employee #: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Job title: \_\_\_\_\_ Area/Department: \_\_\_\_\_

**Do you have or have you ever had:****Y N****Y N**

- ☐ ☐ 1. Head/brain injuries or illness (concussion)
- ☐ ☐ 2. Seizures, epilepsy
- ☐ ☐ 3. Eye problems (except for glasses/contacts)
- ☐ ☐ 4. Ear and/or hearing problems
- ☐ ☐ 5. Heart disease, heart attack or heart surgery
- ☐ ☐ 6. Pacemaker, stents or implantable devices
- ☐ ☐ 7. High blood pressure
- ☐ ☐ 8. High cholesterol
- ☐ ☐ 9. Chronic cough, shortness of breath or breathing problem
- ☐ ☐ 10. Lung disease (asthma, COPD)
- ☐ ☐ 11. Kidney problem or problems with urination
- ☐ ☐ 12. Stomach, liver or digestive problems
- ☐ ☐ 13. Diabetes or blood sugar problems
- ☐ ☐ 14. Anxiety, depression or bipolar disorder

- ☐ ☐ 15. Fainting or passing out
- ☐ ☐ 16. Dizziness, headaches, numbness, tingling or memory loss
- ☐ ☐ 17. Unexplained weight loss
- ☐ ☐ 18. Stroke, mini-stroke, paralysis or weakness
- ☐ ☐ 19. Missing or limited use of any extremity
- ☐ ☐ 20. Neck or back problems
- ☐ ☐ 21. Bone, muscle, joint or nerve problems
- ☐ ☐ 22. Blood disorder, blood clots or bleeding disorder (sickle cell, hemophilia, DVT, PE)
- ☐ ☐ 23. Cancer
- ☐ ☐ 24. Chronic/long term infection
- ☐ ☐ 25. Sleep disorders or loud snoring (sleep apnea)
- ☐ ☐ 26. A broken bone
- ☐ ☐ 27. Have you ever smoked, vaped or used tobacco

List all surgeries and health conditions not covered above:

List all medications (prescription, over-the-counter, herbal remedies, and supplements):

List all allergies to medication or food:

Patient Signature: \_\_\_\_\_ Date Completed: \_\_\_\_\_

Health care provider's comments:

Provider Signature: \_\_\_\_\_ Date Reviewed: \_\_\_\_\_



## Hearing History

Name: \_\_\_\_\_ Employee #: \_\_\_\_\_  
 Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Job title: \_\_\_\_\_ Area/Department: \_\_\_\_\_

Within the last 12 months, have you had any of the following:

- |                                      |             |            |            |
|--------------------------------------|-------------|------------|------------|
| 1. Ear pain?                         | Right _____ | Left _____ | None _____ |
| 2. Drainage from ears?               | Right _____ | Left _____ | None _____ |
| 3. Ringing in your ears?             | Right _____ | Left _____ | None _____ |
| 4. Sudden hearing loss?              | Right _____ | Left _____ | None _____ |
| 5. Hearing loss that comes and goes? | Right _____ | Left _____ | None _____ |
| 6. Feeling of fullness in the ear?   | Right _____ | Left _____ | None _____ |
| 7. Ear discomfort?                   | Right _____ | Left _____ | None _____ |
| 8. Problem with hearing protection?  | Right _____ | Left _____ | None _____ |
| 9. Ear wax problems?                 | Right _____ | Left _____ | None _____ |
| 10. Use of a hearing aid?            | Right _____ | Left _____ | None _____ |

Past noise assessment:

- |                                                                 |           |          |
|-----------------------------------------------------------------|-----------|----------|
| 1. Are you regularly around loud noises?                        | Yes _____ | No _____ |
| 2. Have you had any medical problem that affected your hearing? | Yes _____ | No _____ |
| 3. Are you feeling unwell today?                                | Yes _____ | No _____ |
| 4. In the past have you worked at a job with loud noises?       | Yes _____ | No _____ |
| 5. Does your job require you to wear hearing protection?        | Yes _____ | No _____ |
| 6. Do you have any hobbies that expose you to loud noises?      | Yes _____ | No _____ |
| 7. Do you regularly shoot guns?                                 | Yes _____ | No _____ |
| 8. Have you been in the Armed Services?                         | Yes _____ | No _____ |
| 9. If "Yes" did you fire weapons regularly?                     | Yes _____ | No _____ |

Please explain any "yes" answers:

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The above answers are true and accurate to the best of my knowledge and belief. I realize that any untrue answers may affect my employment, the examiner's recommendations and the validity of this examination.

Patient Signature: \_\_\_\_\_ Date Completed: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date Reviewed: \_\_\_\_\_

## OSHA Respirator Medical Evaluation Update

(To be completed at the time of your appointment, not before)

**Employee and Healthcare Provider to review last year's OSHA Respirator Medical Evaluation Questionnaire**

To the employee:

I have reviewed the OSHA Respirator Medical Evaluation Questionnaire completed within the last 365 days. I certify there are no changes or updates, unless documented below.

Updates:

Patient Signature: \_\_\_\_\_ Date Reviewed: \_\_\_\_\_

Provider notes:

Provider Signature: \_\_\_\_\_ Date Reviewed: \_\_\_\_\_